IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

WILLIAM SERRANO-DIAZ, Plaintiff, v. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	: : : : : : : :	CIVIL ACTION No. 03-6419

MEMORANDUM AND ORDER

J. M. KELLY, J. **OCTOBER , 2004**

Presently before the Court are the Report and Recommendation of United States Magistrate Judge M. Faith Angel on cross-motions for summary judgment, and Plaintiff William Serrano-Diaz's ("Plaintiff") objections thereto. Plaintiff seeks judicial review of the decision of Defendant Commissioner of the Social Security Administration ("Defendant") denying his application for supplemental security income ("SSI") under Title XVI of the Social Security Act, 42 U.S.C. §§ 1381-1383f. Magistrate Judge Angel recommends that the Court grant Defendant's motion for summary judgment and deny Plaintiff's motion for summary judgment. Upon careful and independent consideration of the administrative record, for the following reasons, this Court **OVERRULES** Plaintiff's objections, and **APPROVES** and **ADOPTS** Magistrate Judge Angel's Report and Recommendation. Accordingly, we **DENY** Plaintiff's motion for summary judgment and **GRANT** Defendant's motion for summary judgment.

I. BACKGROUND

A. Undisputed Procedural History

The following procedural history was jointly submitted by the parties pursuant to the April 21, 2004 procedural order of Magistrate Judge Angel.

Plaintiff protectively filed an application for SSI disability benefits on September 8, 1999. (R. 159-60.) Plaintiff alleged an inability to work as of July 1, 1998.[1] Plaintiff amended his disability onset date to September 8, 1999 at his hearing on October 5, 2000. (R. 40.) The Pennsylvania Bureau of Disability Determination (the "state agency") denied Plaintiff's claim initially on January 28, 2000, and upon reconsideration on May 10, 2000. (R. 118-27.)

Upon Plaintiff's request, an administrative law judge (the "ALJ") held a hearing on October 5, 2000. On February 21, 2001, the ALJ issued an unfavorable hearing decision. (R. 36-67, 109-17.) Upon Plaintiff's request for review, the Appeals Council of the Social Security Administration vacated the ALJ's determination and remanded the case to him on March 5, 2002. (R. 153-57.) The Council noted that while the treating source opinion "was not supported by any objective medical

[1] The record indicated that Plaintiff filed a previous application in September 1996, which the state agency denied on January 4, 1997. (R. 22, 39, 178.) Plaintiff did not further pursue that claim. (R. 39-40.)

evidence," it was consistent with the January 2000 consultative examiner's report and, therefore concluded that "additional development [wa]s needed." (R. 155.) The ALJ was ordered to request updated records from Plaintiff's other treating sources, further evaluate Plaintiff's mental residual functional capacity ("RFC"), particularly his ability to interact in a work setting, consider the mental RFC assessment by the state agency psychologist, and provide rationale in accordance with the regulations pertaining to the evaluation of subjective complaints. (R. 155-156.)

On June 10, 2002, a hearing was held at which Plaintiff, who was represented by counsel, testified and submitted additional medical source evidence. (R. 68-100.) A vocational expert also testified. (R. 93, 146.) On September 13, 2002, the ALJ issued an unfavorable hearing decision finding that Plaintiff maintained the residual functional capacity for light exertional level work with additional postural restrictions. (R. 27.) In addition, the ALJ limited Plaintiff to work requiring only simple, repetitive tasks and limited contact with coworkers and the public that would not require him to communicate in English. (R. 27.)

On September 26, 2003, the Appeals Council denied Plaintiff's request for review of the ALJ's decision. (R. 6-9.) Therefore, the decision of the ALJ became the final

decision of the Commissioner.

Plaintiff commenced a civil action for judicial review of the Commissioner's final decision on November 24, 2003. Defendant answered and filed the certified transcript of the administrative proceedings. On March 17, 2003, Plaintiff filed his Motion for Summary Judgment and brief in support thereof. Defendant filed a cross Motion for Summary Judgment and brief on April 15, 2004. On May 3, 2004 Plaintiff filed a response to Defendant's Motion and brief.

Magistrate Judge M. Faith Angel issued a Report and Recommendation that advised this Court to deny Plaintiff's Motion for Summary Judgment and grant Defendant's cross Motion. Plaintiff now objects that Magistrate Judge Angel's Report and Recommendation improperly held that the ALJ's decision was supported by substantial evidence. Specifically, Plaintiff makes the following three objections: (1) that Magistrate Judge Angel incorrectly stated the legal standard for establishing disability under the Social Security Act, (2) that Magistrate Judge Angel incorrectly stated that there was not objective medical evidence, and (3) that Magistrate Judge Angel misstated the facts concerning Plaintiff's mental impairment.

B. Undisputed Medical Facts

While the parties filed separate Statements of Facts as part

of their briefs in support of their Motions for Summary Judgement, the following medical facts were jointly submitted by the parties pursuant to the April 21, 2004 procedural order of Magistrate Judge Angel.

1. Herbert M. Schecter, M.D.

On January 14, 2000, Herbert M. Schecter, M.D., performed a consultative examination of Plaintiff at the request of the state agency. (R. 221-226.) In addition to his narrative report (R. 221-23),[2] Dr. Schecter completed a check-the-box assessment form indicating that Plaintiff could occasionally lift and carry only five pounds, walk or stand only one hour or less, sit only one-to-two hours, and was limited in practically all non-exertional activities (R. 224-225). Dr. Schecter wrote that his "supportive medical findings if not otherwise included in report" were Plaintiff's complaints of "pain" and "s[ymptom] relief." (R. 224-225.)

[2] Dr. Schecter's report noted that Plaintiff's main complaint was a three-year history of back pain not due to any trauma. (R. 221.) Plaintiff stated that he "just woke up with the pain one day." (R. 221.) Dr. Schecter noted that he had not been provided any old records for review. (R. 222.) At the time of his exam, Plaintiff was taking no medication for his back pain. (R. 222.) Dr. Schecter reported Plaintiff's physical examination revealed decreased range of motion with pain. (R. 222.)

2. Paul Perch, Ed.D.

On January 19, 2000, Paul Perch, Ed.D., a non-examining, reviewing psychologist, completed a Psychiatric Review Technique form for the state agency. (R. 226-234.)

Dr. Perch concluded that Plaintiff's anxiety under Listing 12.06 was not a "severe" impairment because it resulted in only "slight" or "seldom" functional limitations. (R. 226- 34.)

3. Sharon Wander, M.D.

On January 26, 2000, Sharon Wander, M.D. a non-examining reviewing medical consultant to the state agency completed a residual functional capacity ("RFC") assessment form. (R. 235-242). Her check marks indicated an RFC for the full range of medium level work. On the form, she indicated that Plaintiff's physical examination was "unremarkable;" his neurological examination "nonfocal." (R. 236, 240.) She opined that Plaintiff's symptoms were partially credible but disproportionate to the normal clinical findings. (R. 240.) She disagreed with the 1/11/00 report of Larry S. Kramer, D.O. (R. 241.)

4. Medical Consultant

On May 3, 2000 another non-examining reviewing medical consultant[3] conferring with the state agency, completed an RFC

[3] This medical consultant's signature is illegible.

assessment form. (R. 273-280.) The medical consultant noted that Plaintiff's normal physical examination was not consistent with Plaintiff's symptoms and, therefore opined that Plaintiff retained the RFC for the full range of medium level work. (R. 274, 278.)

5. Maria de los Santos Health Center Outpatient Treatment Notes

The record contained outpatient treatment notes covering December 14, 1998 through March 7, 2002 from the Maria de los Santos Health Center where Plaintiff was treated by Milagros Soto, D.O., his primary care physician. (R. 196-202, 214-220, 324-329, 341-355.)

On October 2, 2000, Dr. Soto completed the same medical source check-the-box form at Plaintiff's request as that completed by Dr. Schecter. (R. 338-9.) Dr. Soto opined that Plaintiff could occasionally lift and carry only 10 pounds, stand/walk less than one hour, sit six hours, and was limited in almost all non-exertional activities. (R. 338.) Dr. Soto wrote that her "supportive medical findings" were limited upper and lower extremity strength and worsening of "back pain." (R. 338-39.)

6. Northeast Community Mental Health Center

The transcript contained psychotherapy treatment notes, psychiatric treatment notes, psychiatric evaluations and treatment plans from Plaintiff's treating outpatient mental health center, Northeast Community Mental Health Center ("Northeast"), covering the period from December 14, 1999 through May 30, 2002. (R. 243-254, 285-323, 356-405.)

The transcript contained an initial mental status evaluation by a therapist and psychiatrist at Northeast, dated December 14, 1999 and January 11, 2000. (R. 286-97.)[4] Dr. Mahlab noted that Plaintiff appeared neat and age appropriate, he was cooperative and polite, he was oriented to person only, and his speech was adequate. (R. 295.) He also noted that Plaintiff's mood was anxious, his affect blunted; he reported two prior suicidal attempts, but was able to contract for safety; his cognition and memory were "fair," his intelligence "below average," and his insight and judgment were "fair." (R. 296.) The diagnoses were anxiety disorder, not otherwise specified; and Learning Disability ("LD") with a rule out diagnosis of mild mental retardation. (R. 297.) Plaintiff was assigned an Axis V Global

[4] While the signature of this psychiatrist is illegible in the record, Plaintiff's counsel believes it to be the signature of Dr. Ronald Mahlab, a psychiatrist at Northeast Community Mental Health Center. Stephen Rosenfield, the state agency consultative examiner, also reported that Dr. Mahlab had examined Plaintiff. (R. 255.)

Assessment of Functioning ("GAF") score of 30. (R. 297.)

Treatment notes from Northeast, dating between September 2000 and January 2001, indicated that Dr. Mahlab consistently noted that Plaintiff's depression/anxiety were "stable." (R. 322, 368, 370, 374.)

7. Stephen Rosenfield, M.A.

On April 26, 2000, Stephen Rosenfield, M.A., performed a psychological examination of Plaintiff at the request of the state agency. (R. 255-258.) Plaintiff reported a long history of alcohol dependence, but reported having been abstinent for five months. (R. 256.) On mental status examination, Mr. Rosenfield reported a somewhat depressed mood and a tense and nervous affective expression. (R. 257.) His stream of thought appeared to be relatively productive, and his continuity of thought, "easily distractible," possibly from anxiety. (R. 257.) While admitting to a past suicide attempt, Plaintiff denied current suicidal intent. (R. 257.) Mr. Rosenfield reported Plaintiff to be oriented only to person. (R. 258.) On testing, Plaintiff achieved an I.Q. score of only 45 (R. 257), but Mr. Rosenfield opined that the result was a minimal estimate of Plaintiff's current level of functioning in view of Plaintiff's elevated anxiety level (R. 258). Mr. Rosenfield's diagnoses were Adjustment disorder with mixed anxiety and depressed mood,

Alcohol dependence (currently reported to be in partial remission) and Mild mental retardation. (R. 258.)

Mr. Rosenfield reported that the "Effect of Impairment On Functioning" was as follows: Plaintiff reported that his wife performed all activities of daily living for him; Plaintiff reported that he interacted with family and friends in a fair to reasonable manner. Based upon Plaintiff's report of easy distraction, Mr. Rosenfield opined that "his ability to remember appointments independently and to complete assignments or to sustain work or work-like related activities appear to be questionable at this point." (R. 258.)

8. Linda Mascetti, Ph.D.

On May 2, 2000, another non-examining reviewing psychologist, Linda Mascetti, Ph.D., completed a Psychiatric Review Technique form for the Pennsylvania State Agency. (R. 264-272.) She concluded that there was a "severe" nonlisting level mental impairment with a co-existing nonmental impairment. (R. 264.) She assessed Plaintiff's mental impairments under two categories, 12.09 (substance addiction disorders) and 12.08 (personality disorders). (R. 271.) Dr. Mascetti did not consider Plaintiff credible because of inconsistent histories given by Plaintiff. (R. 265.) She also noted that Plaintiff's I.Q. scores were not consistent with his personal and past work

histories or with his behavior at medical appointments. (R. 265.) She concluded that Plaintiff had a moderate restriction in activities of daily living; a moderate restriction in maintaining social functioning; would "often" have deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner; and never had episodes of deterioration or decompensation in work or work-like settings. (R. 271.)

9. Oscar Saldaña, M.D.

On August 14, 2000, Oscar Saldaña, M.D., an examining and supervising psychiatrist at Northeast (R. 298, 300, 302, 304) completed an assessment form concerning Plaintiff's mental abilities to perform work-related activity. Dr. Saldaña indicated that Plaintiff had only fair-to-no ability to make occupational and performance work-related adjustments. (R. 283-84.) His "findings that support this assessment" were that Plaintiff "tends to forget and cannot follow through with simple requests," and that Plaintiff "prefers not to do things and is unpredictable, gets confused on days and time." (R. 283-84.)

In April 2001, a psychiatrist at Northeast, Dr. "Ballas" (name illegible) performed a mental status evaluation. (R. 357-67.) Dr. Ballas noted that Plaintiff was oriented to person only. (R. 365.) His diagnoses were anxiety disorder, rule out

impulse control, and LD rule out mental retardation ("MR"). (R. 367.) He rated Plaintiff's GAF at 55. (R. 367.) Between 2001-2002, treatment notes from Northeast indicated that Dr. Ballas noted that Plaintiff's depression/anxiety was "stable." (R. 382, 384, 386-87, 389, 391, 393, 397, 399, 404-05.)

II. STANDARD OF REVIEW

The Social Security Act provides for judicial review of any "final decision of the Commissioner of Social Security" in a disability proceeding. 42 U.S.C. § 405(g). The district court may enter a judgment "affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing." Id. However, the Commissioner's findings "as to any fact, if supported by substantial evidence, shall be conclusive." Id. Accordingly, the Court's scope of review is "limited to determining whether the Commissioner applied the correct legal standards and whether the record, as a whole, contains substantial evidence to support the Commissioner's findings of fact." Schwartz v. Halter, 134 F. Supp. 2d 640, 647 (E.D. Pa. 2001).

Substantial evidence has been defined as "more than a mere scintilla" but somewhat less than a preponderance of the evidence, or "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v.

Perales, 402 U.S. 389, 401 (1971); Jesurum v. Sec. of the United States Dep't of Health & Human Servs., 48 F.3d 114, 117 (3d Cir. 1995). The standard is "deferential and includes deference to inferences drawn from the facts if they, in turn, are supported by substantial evidence." Schaudeck v. Comm'r of S.S.A., 181 F.3d 429, 431 (3d Cir. 1999).

In reviewing Magistrate Judge Angel's Report and Recommendation, this Court must review de novo only "those portions" of the Report and Recommendation "to which objection is made." See 28 U.S.C. § 636(b)(1).

III. DISCUSSION

Plaintiff filed three objections to Magistrate Judge Angel's Report and Recommendation. First, Plaintiff argues that Magistrate Judge Angel improperly stated that Plaintiff must be "totally" disabled to receive SSI disability benefits and had the Magistrate Judge properly evaluated Plaintiff's disability pursuant to the Social Security Act she would have found him to be disabled under the Act. Second, Plaintiff contends the record contradicts Magistrate Judge Angel's conclusion that there is no objective medical evidence to support Plaintiff's claim of disability. Finally, Plaintiff appears to claim that Magistrate Judge Angel erroneously evaluated the evidence regarding

Plaintiff's mental impairments.

Magistrate Judge Angel, in her Report and Recommendation, found that the ALJ's determination met the substantial evidence threshold. Nevertheless, upon independent review and consideration of the entire record, this Court addresses each of Plaintiff's objections in turn.

A. Legal Standard for Establishing Disability under the Social Security Act

Plaintiff objects to Magistrate Judge Angel's characterization of the legal standard for establishing disability under the Social Security Act. Plaintiff contends that Magistrate Judge Angel, in her Report and Recommendation ("R&R"), improperly evaluated the evidence in this matter under a legal standard that would award SSI disability benefits only after a finding of "total" disability. Plaintiff then identifies the correct legal standard, which requires a five step sequential evaluation process that takes into account a claimant's residual functional capacity based on medical factors and consideration of vocational factors. A simple reading of Magistrate Judge Angel's R&R, however, reveals that she implemented the exact legal

standard that Plaintiff argues should have been used.[5] Therefore, we are unconvinced that the Magistrate Judge applied the wrong legal standard in this matter.

B. Objective Medical Evidence Misstatement

Plaintiff contends that the record contradicts Magistrate Judge Angel's statement that, "the medical evidence is silent as to objective findings based on clinical testing and/or prescribed pain medication to support exertional pain-producing impairment(s)." (R&R at 4.) Specifically, Plaintiff contends that the 2002 x-ray of Plaintiff's shoulder and the prescriptions of relafen, motrin, tylenol with codeine and naproxen constitute objective medical evidence that contradict the Magistrate Judge's statement. In making his argument, Plaintiff ignores the fact that Magistrate Judge Angel's statement contains two parts. Not only must there be objective medical evidence of a disability, but the Magistrate Judge found that there must also be evidence

[5] Magistrate Judge Angel addresses the applicable legal standards over the span of two pages within her R&R. Within this legal standards section of her R&R, Magistrate Judge Angel discusses the need for substantial evidence, a medically determinable basis for an impairment, and the five step sequential evaluation process in deciding whether to deny disability benefits. In light of the clearly written legal standards section of the R&R, we view Magistrate Judge Angel's one-time use the term "total disability," which is found in a separate section of the R&R, as nothing more than a poor word choice. At no point did Magistrate Judge Angel apply the "total disability" standard that Plaintiff alleges.

that there is an exertional pain-producing impairment.

It follows from the Magistrate Judge's statement, that she first reviewed the record for objective medical evidence of a physical disability. Evidence in the record suggests that Plaintiff's prescriptions are not objective medical evidence because each pain medication was prescribed based on Plaintiff's subjective complaints of pain. The 2002 shoulder x-ray and MRI, however, constitute objective medical evidence of a possible disability. The Magistrate Judge next reviewed whether this objective evidence constituted an exertional pain-producing impairment. Merriam-Webster's Medical Desk Dictionary defines "exertional" as something "precipitated by physical exertion but usually relieved by rest." Merriam-Webster's Medical Desk Dictionary, Revised Edition (Merriam-Webster, Inc., 2002). Since the x-ray did not show any abnormalities or impingement, and the MRI of the left knee showed only "some" tendinosis, the Magistrate Judge correctly concluded that this evidence does not support an exertional pain-producing impairment. There was no objective medical evidence that Plaintiff experienced pain aggravated by physical exertion to justify a finding of disability under the Social Security Act. See 20 C.F.R. § 416.920(a)(4)(iii) (2004) (providing that the criteria of the listings are objective medical findings which demonstrate per se

disability).[6]

C. Plaintiff's Mental Impairment Misstatement

Plaintiff appears to claim that Magistrate Judge Angel erroneously evaluated the evidence regarding Plaintiff's mental impairments when she "attributed statements of a non-examining reviewer to the consultative examining psychologist, Stephen Rosenfield." (Pl.'s Obj. at 4.) We agree that Magistrate Judge Angel's evaluation seems to mistakenly attribute one statement to Dr. Stephen Rosenfeld in making her determination regarding non-exertional impairments. Accordingly, we will review whether there was substantial evidence to support the ALJ's findings of fact regarding Plaintiff's alleged mental impairments.

1. Legal Standard

Where there is evidence of mental impairment that allegedly prevents a claimant from working, the Commissioner must follow the procedure set forth in 20 C.F.R. § 404.1520a. Plummer v. Apfel, 186 F.3d 422, 432 (3d Cir. 1999). "These procedures are

[6] Additionally, Plaintiff's alleged physical ailments do not appear to be objectively severe as he has not proffered any evidence of surgery, injections, physical therapy, or chiropractic care. See Dumas v. Schweiker, 712 F.2d 1545, 1553 (2d Cir. 1983) (holding that the Commissioner is entitled to rely not only on what the record says, but also on what it does not say).

intended to ensure a claimant's mental health impairments are given serious consideration by the Commissioner in determining whether a claimant is disabled." Id. Under these procedures, the ALJ must first evaluate the claimant's pertinent symptoms, signs, and laboratory findings to determine whether he or she has a medically determinable mental impairment. 20 C.F.R. §404.1520a(b)(1).

If a medically determinable mental impairment is found, the ALJ must then rate the degree of functional limitation resulting from the impairment. §404.1520a(b)(2). To perform this latter step, the ALJ should assess the claimant's degree of functional limitation in four areas: (1) activities of daily living; (2) social functioning; (3) persistence or pace of concentration; and (4) episodes of decompensation. §404.1520a(c)(3). If the degree of limitation in the first three functional areas is "none" or "mild," and "none" in the fourth area, the ALJ will generally conclude that the impairment is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in the claimant's ability to do basic work activities. §404.1520a(d)(1).

2. Plaintiff was not Credible

The ALJ determined that Plaintiff was not credible in his

testimony or during intelligence tests, which, in turn, lessens the reliability of the medical evidence in the record that relies on Plaintiff's complaints. Further, the ALJ found that while Plaintiff's mental impairment, which consists of anxiety and depression, was more significant than the alleged physical impairments, there were no valid intelligence tests to support Plaintiff's contention that this impairment is severe.

a. Plaintiff's Testimony

The ALJ found that Plaintiff's testimony was not completely credible or consistent with the record. It is suggested that Plaintiff's repeated inconsistencies may be the product of his attempts to manipulate his testimony and performance during mental assessment tests for the purpose of obtaining SSI disability benefits. The following are examples of inconsistencies in Plaintiff's testimony:

(1) Although Plaintiff indicated on his application that he went to the 12th grade (R. 175), he testified that he only went to school for a total of four years (R. 43). He emigrated to the United States from Puerto Rico in approximately 1995, but told the ALJ that he did not understand the English language. (R. 44). The ALJ asked to have the record reflect that Plaintiff answered certain questions before the interpreter translated them into Spanish (R. 44-45);

(2) Plaintiff stated that he last worked ten years ago as a construction laborer, which

according to Vocational Expert testimony, was an unskilled position performed at the heavy exertional level. (R. 45, 93). He also stated that he worked five years ago as a machine watchman; however, no earnings were reported on his record (R. 46-47);

(3) Plaintiff reported that he was drinking "daily" in December 1999 (R. 249); in April 2000, he reported that despite "chronic alcohol dependence," he gave up alcohol (R. 255);

(4) during his consultative psychological evaluation, Plaintiff responded that the color of grass was red, the shape of a ball was square; he stated that he did not know how many months were in a year or why birds have wings; he could not count from one to seven (R. 257);

(5) he stated that his wife (who receives SSI and whose illness causes Plaintiff great anxiety) performs all of Plaintiff's activities of daily living for him including all of the household chores (R. 258, 316-17, 380, 388);

(6) he reported that his anxiety is due to his medical condition, but treatment notes indicated that he stopped his diabetes medication, took his wife's Xanax, and went off Paxil by his own decision (R. 328, 367, 403);[7] and

(7) depending on his family situation, Plaintiff reported that his sleeping and eating

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[7] See 20 C.F.R. § 416.930 (2004) (stating that in order to receive benefits, a claimant must follow prescribed treatment; if treatment is not followed without good reason, a claimant will not be found disabled); see also Brown v. Bowen, 845 F.2d 1211, 1215 (3d Cir. 1988) (stating that if treatment or medication can control an impairment, it cannot be considered disabling).

> patterns ranged from not well to normal (R. 359).

Throughout the record, Plaintiff complains about symptoms of mental impairment that he believes to be severe, however, his testimony is inconsistent with itself and with the treatment recommended by physicians.

b. Medical Evidence

The substantial medical evidence supports the ALJ's finding that Plaintiff is mentally capable of performing light exertional level work with additional postural restrictions. Various doctors discredited the severeness of Plaintiff's complaints. For example, Dr. Wander found that Plaintiff's symptoms were partially credible but disproportionate to the normal clinical findings. (R. 240.) Dr. Wander performed a physical examination of Plaintiff and found it to be "unremarkable." (R. 236.) Dr. Mascetti did not consider Plaintiff credible because of inconsistent histories given by Plaintiff. (R. 265.) The ALJ found that Dr. Saldaña's mental residual functional capacity assessment was extreme and poorly supported only by Plaintiff's subjective complaints, including a statement by Plaintiff that he "prefers not to do things." (R. 284.)

Relying on substantial evidence, the ALJ properly discredited each medical record that based its findings on

Plaintiff's subjective complaints. See 20 C.F.R. § 416.929 (2003) (providing that the ALJ is the ultimate fact finder and has the responsibility for making determinations of a claimant's credibility); see also SSR 96-7p (requiring that findings about the credibility of an individual's statements about symptoms and their functional effects be made by the adjudicator); Van Horn v. Schweiker, 717 F.2d 871, 873 (3d Cir. 1983) (same).

3. Plaintiff's Mental Impairment is not Work-Preclusive

The ALJ found that Plaintiff maintained the residual functional capacity for light exertional level work with additional postural restrictions. Dr. Wander indicated that Plaintiff has the RFC for medium level work. Dr. Mahlab from Northeast observed that Plaintiff appeared neat, age appropriate, was cooperative and polite. (R. 295.) Treatment notes from Northeast during the years 2000 and 2001 indicate that Plaintiff's depression and anxiety were stable. (R. 322, 368, 370, 374.) Dr. Rosenfield noted that Plaintiff has a relatively productive continuity of thought. (R. 257.) Therefore, the ALJ properly credits a more recent GAF score of 55, which Dr. Ballas indicates is not work-preclusive, on the basis that the score is consistent with Northeast treatment notes. Substantial evidence supports the ALJ's finding that Plaintiff's mental impairment is

not work-preclusive.

4. The ALJ Applied the Correct Legal Standard

Following a reasoned analysis of the record, the ALJ in this matter determined that Plaintiff's alleged mental impairment was non-severe depression and anxiety. Analyzing the four areas of functioning, the ALJ determined that Plaintiff had mild restrictions in activities of daily living, moderate difficulties in maintaining social functioning, moderate deficiencies of concentration, and no episodes of deterioration at work or in work-like settings. (R. 27.)

Plaintiff had the burden to show his physical and/or mental infirmaries resulted in some functional limitation on his ability to do basic work activity. See Colavito v. Apfel, 75 F. Supp. 2d 385, 400 (E.D. Pa 1999). In view of the lack of objective medical evidence and the abundance of evidence tainted by Plaintiff's subjective testimony, the ALJ's denial of SSI disability benefits was supported by substantial evidence. Therefore, we reject Plaintiff's objections, and the ALJ's determination shall not be disturbed.

III. CONCLUSION

Upon a thorough and independent review of the record, for these foregoing reasons, this Court **OVERRULES** Plaintiff's objections, and **APPROVES** and **ADOPTS** Magistrate Judge Angel's Report and Recommendation as supplemented by this Memorandum. Accordingly, Defendant's Motion for Summary Judgment is **GRANTED** and Plaintiff's Motion for Summary Judgment is **DENIED**.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

WILLIAM SERRANO-DIAZ,	:	CIVIL ACTION
Plaintiff,	:	
	:	
v.	:	
	:	
JO ANNE B. BARNHART,	:	
Commissioner of Social Security,	:	
Defendant.	:	No. 03-6419

O R D E R

AND NOW, this 28th day of October 2004, upon careful and independent consideration of United States Magistrate Judge M. Faith Angel's Report and Recommendation (Doc. No. 19) and Plaintiff William Serrano-Diaz's ("Plaintiff") Objections thereto (Doc. No. 20), **IT IS ORDERED** that:

1. Plaintiff's Objections to Magistrate Judge Angel's Report and Recommendation are **OVERRULED**.

2. Magistrate Judge Angel's Report and Recommendation is **APPROVED** and **ADOPTED** as supplemented by the foregoing memorandum.

3. Plaintiff's Motion for Summary Judgment (Doc. No. 6) is **DENIED**.

4. Defendant's Motion for Summary Judgment (Doc. No. 7) is **GRANTED**.

5. The Clerk of Court is hereby directed to mark this case closed for administrative purposes.

BY THE COURT:

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JAMES McGIRR KELLY, J.